

Massachusetts Department of Public Health Split Sample Testing Fluoridation Report-Form C

Purpose: This form is to be used by the public water system (PWS) to evaluate the accuracy of the PWS fluoride testing equipment or laboratory. Each month, at least one (1) distribution sample **MUST** be split and analyzed by the PWS and a Massachusetts certified laboratory.

Directions:

1. Enter the monitoring period in month/year format.

Section 1: Sampling Instructions: PWS are required to following the actions as outlined under Section I

Section II: PWS Information:

- A. 1. Enter 1. the system name; 2. 7-digit MassDEP assigned Public Water System identification number; 3. City, Town or District; 4. MassDEP Source Code(s) and Location ID/Name for contributing fluoride sources;
5. Name of the operator performing the sample analysis; and 6. Make/Model # of PWS fluoride analyzer.
- B. 1. Enter the Sample # (example 01F) or Location Name/Address of the Distribution Site from Form B
2. Enter the ID # of the bottle used for the sample
3. Enter the result obtained by the water system to the nearest 0.1 ppm
4. Enter the operators name who collected/analyzed the sample
5. Enter the date the split sample was taken in month/day/year format
6. Enter the date the split sample was analyzed by the PWS in month/day/year format
7. Enter the certified operator or person responsible; 8. Sign and date the form; and 9. Complete the PWS contact information

Section III: Laboratory Analytical Information: To be completed/signed by a Certified Laboratory

Note: The PWS must contact the Office of Oral Health within 7days of learning that the laboratory result was not within +/- 0.1 of the result listed by the PWS for sample 01F

**** Form A, B, and C must be returned to the Massachusetts Department of Public Health Office of Oral Health by the 10th day following the reporting month**

Electronic copies of all forms are located at DPH Office of Oral Health

<http://www.mass.gov/dph/fch/ooh.htm> and MassDEP/DWP <http://www.mass.gov/dep/water/>

MASS/DEPARTMENT OF PUBLIC HEALTH DPH-FL-C (monthly)

MONTHLY DISTRIBUTION SYSTEM SPLIT TESTING FLUORIDATION REPORT

Month of _____, 20____ Page ____ of ____

The data from this report will be used to evaluate the accuracy of the PWS fluoride testing equipment or laboratory.
 Each month, at least one (1) distribution sample must be split and analyzed by the PWS and a Mass. laboratory certified for fluoride.¹
 Any questions, please call the Mass DPH Fluoridation Program at 617-624-6074.

Section I. PWS SAMPLING INSTRUCTIONS (PWS are required to take the following actions)

1. Collect a fluoride sample from the location checked on Form FL-B.
2. Divide the sample into two. The PWS must analyze one portion ("A") for fluoride using Std. Methods approved analytical method for fluoride analysis. e.g. specific ion or colorimetric method. The other portion of the sample ("B" or "split sample") must be sent for analysis within 96 hours of collection, to a laboratory that is certified by MassDEP for fluoride analysis.¹
3. Record below, in Section II, all requested information for portion "A".

Section II. PWS INFORMATION: (To be completed and signed by PWS)

1. PWS Name: _____
2. PWS ID#: _____
3. City/Town or District: _____
4. List all contributing fluoridated source(s)/MassDEP Source Code/Location ID: _____
5. Name of PWS operator performing sample analysis: _____
6. Make and Model # of PWS fluoride analyzer: _____

Sample # or Location Name & Address from Form FL-B	Bottle #	Results (PPM) (To the nearest 0.1)	Sample Collector's Name (Print)	Date Sample Collected by PWS	Date Sample Analyzed by PWS

I certify under penalty of law that I am the person authorized to fill out this form and the information contained herein is true, accurate and complete to the best of my knowledge and belief.

Name of PWS operator or responsible party: _____ Signature: _____ Date: _____
 Phone #: _____ Fax#: _____ Email address: _____

Section III. LABORATORY ANALYTICAL INFORMATION: (To be completed and signed by Lab)

Lab name: _____ MassDEP Lab Cert.#: _____ Lab phone: _____
 Lab address: _____

Is this lab certified by MassDEP for fluoride analysis? Yes ☐ No ☐. If no, is a subcontracted lab used? Yes ☐ No ☐

Subcontracted lab name: _____ Sub lab MassDEP Cert #: _____

Is this subcontracted laboratory certified by MassDEP for fluoride analysis? Yes ☐ No ☐

Sample Location No.	Sample Location Name & Address	Bottle #	Lab sample ID#	Results (PPM) (To the nearest 0.1)	Detection limit	Analytical Method	Date Analyzed

My certified analytical results for the sample listed by the PWS as 01F is _____. _____ PPM.

Check the correct answer: ☐ **My laboratory result is Within** +/- 0.1 of the result listed by the PWS for 01F.

☐ **My laboratory result is Not Within** +/- 0.1 of the result listed by the PWS for 01F.*

*PWS must contact the Office of Oral Health at 617-624-6074 within 7 days of learning of this checked result.

I certify under penalty of law that I am the person authorized to fill out this form and the information contained herein is true, accurate and complete to the best of my knowledge and belief.

Name of Laboratory Director: _____ Signature: _____ Date: _____

¹ If a PWS uses a Mass. certified lab for its daily samples it must use a different Mass. certified lab. for the required split sample.

Section IV. DPH USE ONLY

Date received _____ Approved: _____ Deficient/Comments: _____

Within 30 days of receipt of results and no later than 10-days after the end of the reporting period, PWSs approved by MassDEP for Fluoridation treatment must mail 1 copy of each page of this report form (A, B, & C) to: MA Dept. of Public Health, 250 Washington Street, 5th Floor, Boston, MA 02108-4619 Att: Office of Oral Health